STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155769	A. BUILDING 00 B. WING	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISON WOODS HEALTH CAMPUS	4100 N MORRISON RD MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 23, 24, 27, and 28, 2011 Facility number: 011596 Provider number: 155769 AIM number: N/A Survey team: Karen Lewis, RN -TC Delinda Easterly, RN Betty Retherford, RN Ginger McNamee, RN Census bed type: SNF: 46 Residential: 30 Total: 76 Census payor type: Medicare: 23 Other: 53 Total: 76 Stage 2 Sample: 27 Residential Sample: 8 These deficiencies reflect State findings cited in accordance with 410	F0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey of 2/28/2012.Please accept this plan of correction as the provider's credible allegation of compliance. The Provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	IAC 16.2. Quality review completed on March 5, 2012, by Bev Faulkner, RN			

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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure residents were informed of possible charges that could be incurred as a result of the lack of Medicare coverage benefits for 2 of 3 residents reviewed who had received notification of Medicare non-coverage. (Resident #'s 31 and 32) Findings include: Review of the "Notice of Medicare Provider Non-Coverage" letters for Resident #'s 31 and 32 on 2/27/12 at 1:30 p.m., indicated the letters lacked information related to a list of items and services with charges for non-Medicare residents and what the	F0156	The 2 residents who were affected by the alleged deficient practice have been discharged home. All current and future Medicare recipients residing on the skilled unit have the potential to be affected by this alleged deficient practice. The Medicare denial letters have been updated and will include the daily semi-private room rate the resident would be responsible for paying if they choose to remain in the facility after Medicare Part A coverage ends. A copy of the letter signed by the resident or the responsible party will be maintained in the resident's business file. To ensure that this alleged deficient practice does not recur, other staff members who may be responsible for completing the letters were inserviced on the new format and the vital importance of including the daily room rate in the letter.	03/23/2012

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	resident's daily rate would be when Medicare services were discontinued. During an interview on 2/27/12 at 3:00 p.m., the Administrator indicated she was not aware it was necessary to have this information listed on the non-coverage letters and would implement that procedure on future letters. 3.1-4(a) 3.1-4(f)(3)		The letters will be audited weekly at the Medicare meeting by the Bookkeeper or the Executive Director for 8 weeks and monthly thereafter X 6 months to ensure substantial compliance is achieved. The audits will be reviewed at our monthly Quality assurance meeting X 6 months to ensure they are accurate and complete. Business Office Manager/ Executive Director to monitor.	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure a comprehensive plan of care was developed for a resident's diagnosis of anemia requiring lab monitoring and medication administration for 1 of 10 residents reviewed for health care planning related to diagnoses and/or medication use. (Resident #27) Findings include: 1.) The clinical record for Resident #27 was reviewed on 2/27/12 at 8:35 a.m.	F0279	The corrective action accomplished for the resident found to have been affected by the alleged deficient practice: An anemia care plan for Resident number 27 was initiated on 2/27/2012.Other residents with the potential to be affected by the same alleged deficient practice: All residents with a diagnosis of anemia were identified and their care plans were audited to ensure the anemia care plan was complete.Measures put in place to ensure that the alleged deficient practice does not recur: the DHS or her designee will re-educate the campus care plan	03/23/2012

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	Diagnoses for Resident #27 included, but were not limited to, fracture of the right ankle and bipolar disorder. Hospital laboratory reports, dated from 11/26/11 through 11/30/11, indicated Resident #27's hemoglobin (hgb) (a measurement of the iron content of the blood) levels were low on each of those dates. The resident's hgb levels ranged from 9.8 to 10.6. The form indicated a level between 12 and 15.5 was within normal limits. A physician's progress note, dated 12/4/11, indicated the physician had visited the resident and had added a new diagnosis of anemia. New orders were also received for folic acid, 1 milligram (mg) daily for anemia and for a CBC (complete blood count) (a test which includes the hgb level) order. The resident also had an admission physician's order, dated 12/1/11, for Thera Vitamin, one tablet daily as a vitamin supplement. A lab report, dated 12/5/11, indicated the resident's hgb remained low at 11.0. The clinical record indicated health care plans for Resident #27 were last		team on the Interdisciplinary team care plan guidelines. Corrective measures will be monitored to ensure that the alleged deficient practice does not recur: DHS or designee will audit 4 care plans per week X 60 days, then monthly thereafter X 4 months to ensure a comprehensive care plan is in place related to residents with anemia diagnosis. The audits will be presented to the monthly Quality Assurance committee times 6 months for further recommendation.	

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	reviewed on 1/2/12. The comprehensive health care plan lacked any health care planning related to the resident's diagnosis of anemia requiring medication administration and laboratory testing. During an interview with the RN Consultant on 2/27/12 at 10:45 a.m., additional information was requested related to the lack of any health care planning for the resident's diagnosis of anemia. During an interview on 2/27/12 at 11:30 a.m., the RN Consultant indicated no comprehensive health care plan had been developed related to the resident's diagnosis of anemia and the staff would develop one "today". 3.1-35(a)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on interview and record review, the facility failed to ensure 1 of 2 residents reviewed of the 5 who met the criteria for urinary continence decline was assessed for the cause of the decline and received care to promote continence. (Resident #107) Findings include: Resident #107's clinical record was reviewed on 2/27/12 at 9:21 a.m. The resident's diagnoses included, but were not limited to, fractures of the right and left hips, chronic frozen right shoulder, and stroke. The resident had a 10/25/11, admission Minimum Data Set [MDS] assessment. The assessment indicated the resident's cognition was moderately impaired, needed the assistance of one for toileting, and	F0315	The corrective action accomplished for the resident found to have been affected by the alleged deficient practice: A bladder/elimination assessment will be completed for resident 107. If the assessment identifies the cause of the decline and it is determined that the resident may benefit from a toileting program, nursing will complete a 72 hour elimination tracking. Interventions and careplan will then be updated.Other residents with the potential to be affected by the same alleged deficient practice: All current residents with urinary continence decline have the potential to be affected. All current residents will be assessed for a decline in urinary continence for the past 30 days. Those residents identified with a decline, a bladder/elimination assessment will be completed. If the assessment identifies the cause of the decline and it is dertermined that the resident may	03/23/2012

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	was occasionally incontinent of urine or incontinent of urine less than seven times during the assessment period. The resident had a 1/12/12, quarterly MDS assessment indicating there was no change in the resident's cognition or need of assistance with toileting. The assessment did indicate the resident was frequently incontinent of urine or was incontinent greater than seven times during the assessment period. A care plan meeting was held on 11/1/11 and 2/1/12. The resident had a care plan problem initiated on 11/2/11 and continued on 2/12/12 for alteration in urinary elimination as evidenced by urinary incontinence related to lack of impaired mobility. The goal was the resident will not develop alteration in skin integrity and will not exhibit symptomatic urinary tract infection as evidenced by no fever. The interventions were incontinence management program. Monitor for incontinence and change as needed. Provide pericare after each episode. A barrier/ointment/lotion after each episode when ordered. Encourage oral fluid intake. Monitor for signs and symptoms of urinary tract infection such as fever, changes in		benefit from a toileting program, nursing will complete a 72 hour elimination tracking. Interventions and careplans will be updated.Measures put in place to ensure that the alleged deficient practice does not recur: The DHS or designee will re-educate the nursing staff on the guideline for Bowel and Bladder Continence.Corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DHS or designee will complete a weekly review of the current residents to identify any decline in urinary incontinence. Those residents noted with a decline will have a bladder/elimination assessment completed. If the nursing assessment identifies the cause of the decline and it is determined that the resident may benefit from a toileting program, nursing will complete a 72 hour elimination tracking. Interventions and careplan will be updated. This monitoring will be ongoing.The audits/reviews will be presented monthly to the QA committee times 6 months for further recommendation.	

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	mental or functional status, burning with urination, flank pain, changes in color or clarity of urine. The care plan lacked a toileting schedule or intervention to promote continence for the resident. During an interview on 2/28/12 at 8:39 a.m., with MDS Coordinator #1, She indicated she initiates care plan problems from the MDS assessments. She indicated the care tracker documenting system tells her what number to put on the MDS assessment for continence. She indicated she does not look at the actual continence records for each day of the assessment period for the resident. MDS Coordinator #1 indicated she does not look at changes in voiding patterns and does not look for possible causes of changes. She indicated Resident #107 should be toileted upon rising and before meals. She indicated the floor nurse should notify the resident's doctor when there is a change with the resident's continence status. During an interview with the RN Consultant on 2/28/12 at 9:50 a.m., she indicated Resident's #107's admission 72 hour voiding pattern record had not been completed. She indicated a 72 hour voiding pattern			

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	should be completed when there is a decline in the resident's voiding pattern to look for causes or new interventions to maintain the resident's continence. Review of the current facility policy, undated, titled "Bowel and Bladder Continence," provided by the Administrator on 2/28/12 at 10:32 a.m., included, but was not limited to, the following: "PURPOSE: To provide measures for a resident who is incontinent to receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Procedure: Complete a bowel and bladder assessment as part of the Admission Nursing assessment and implement care plan interventions as appropriate. If nursing assessment reveals the resident may benefit from a toileting program, complete the 72 Hour Elimination Record to establish a bowel and bladder pattern. Urinary incontinence is often a symptom of a condition and bay be reversible. It is important to			

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	understand the cause and address incontinence to the extent possible. If the cause for incontinence is reversible or able to be partially mitigated a Continence Program should be established with routine toileting times as indicated by the patterns established in the Elimination Record or at designated times such as upon rising, before/after meals and at bedtime.... ...If a resident requires a structured continence program they should be placed in a restorative nursing program with documentation completed per the program guidelines.... ...The elimination care plan should include individualized interventions to maintain or improve continence status or a clean, dry condition for those unable tor reestablish continence. The bowel and bladder status and care plan shall be re-evaluated quarterly and PRN with changes made as indicated...." 3.1-41(a)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure kitchen pans were clean and in good repair. This deficient practice had the potential to affect 45 residents who receive trays from the kitchen from the population of 46. Findings include: During the initial tour of the kitchen on 2/23/12 at 8:45 a.m., with the Dietary Manager present, there were four muffin tins discolored with dark brown or black residue build up. The Dietary Manager indicated the muffin tins needed to be discarded. There was a round spring form cake pan stored as clean. The bottom of the pan was covered with rust and the Dietary Manager indicated the pan was not suitable for use. There was a seven inch non-stick skillet stored as clean. The handle of the skillet had a dime size yellow dried substance on it and the non-stick finish was flaked off of the	F0371	All residents residing in the facility have the potential to be affected by this alleged deficient practice. All pans in the kitchen were cleaned and dried or discarded if they were discolored or in dis-repair. Current and future residents of the facility have the potential to be affected by this alleged deficient practice. All staff in the dietary department have been inserviced on the proper procedure for cleaning and drying the pans as well as the importance of immediately discarding any pans or utensils found to be discolored or in a state of dis-repair. To ensure that this alleged deficient practice does not re-occur, the Director of Food Service will audit all pans and cooking utensils used in the kitchen weekly for 8 weeks and monthly times 4 to ensure substantial compliance is achieved. The audits will be reviewed at the monthly Quality Assurance Meeting for 6 months. Director Food Service/Assistant Director of food Service to monitor.	03/23/2012

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	155769	A. BUILDING 00 B. WING	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISON WOODS HEALTH CAMPUS	4100 N MORRISON RD MUNCIE, IN 47304

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	inside of the skillet. 3.1-21(i)(3)			

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F0507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Based on record review and interview, the facility failed to ensure the nursing staff followed-up on a missing laboratory test to ensure the lab results were in the clinical record for 1 of 10 residents reviewed for laboratory testing related to diagnoses and/or medication use. (Resident #27) Findings include: 1.) The clinical record for Resident #27 was reviewed on 2/27/12 at 8:35 a.m. Diagnoses for Resident #27 included, but were not limited to, fracture of the right ankle and bipolar disorder. A physician's progress note, dated 12/4/11, indicated the physician had visited the resident and had added a new diagnosis of anemia. New orders were also received for folic acid 1 milligram (mg) daily for anemia and for a CBC (complete blood count) order (a test which includes a hgb	F0507	The corrective action accomplished for the resident found to have been affected by the alleged deficient practice: Resident 27 lab result was placed on chart on 2/27/12.Other residents with the potential to be affected by the same alleged deficient practice: All current resident's medical records will be audited for the past 30 days to ensure all completed labs are filed in the medical record. Measures put in place/systemic changes made to ensure that this deficient practice does not recur: DHS or designee will re-educate Licensed nurses on the guideline for Lab tracking.Corrective measures will be monitored toensure the deficient practice does not recur: DHS or designee will complete an audit 5 times per week times 30 days, then weekly times 5 months to ensure labs completed are filed on the medical record.The audits will be presented to the monthly QA committee times 6 months for further recommendations.	03/23/2012

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	level). The resident also had an admission physician's order, dated 12/1/11, for Thera Vitamin, one tablet daily as a vitamin supplement. A lab report, dated 12/5/11, indicated the resident's hgb remained low at 11.0. A physician's order, dated 2/2/12, indicated Resident #27 was to have multiple lab tests drawn the following morning including a CBC. The clinical record contained the other lab tests, but lacked any report for a CBC. During an interview with the RN Consultant on 2/27/12 at 10:45 a.m., additional information was requested related to the missing CBC report. During an interview on 2/27/12 at 11:30 a.m., the RN Consultant provided a copy of a CBC report, dated 2/3/12, and indicated she had been unable to find the report in the resident's clinical record and had asked the laboratory provider to fax them a copy of the report. She did not know why the report was not present in the clinical record with the other tests drawn on that date or if the doctor had received the CBC results			

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	at his office. She indicated she did not know why the nursing staff had not followed up on the missing test report. The CBC report, dated 2/3/12, indicate the resident's hgb level was 11.4 and designated the level as "low." 2.) Review of the current facility policy, dated 11/22/08, titled "LAB TRACKING GUIDELINES," provided by the Administrator on 2/28/12 at 10:32 a.m., included, but was not limited to, the following: "PURPOSE: To facilitate a method of tracking laboratory tests ordered and monitor test has been completed in a timely manner to identify and to treat infections and/or make medication adjustments. POLICY: 1. When an order is received for a laboratory test it shall be added to the 'Lab Tracking Log'. 2. The nursing staff or person designated by the Executive Director or Director of Health Services shall monitor the 'Tracking Log' to ensure tests have been completed per the physician order.			

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	3. When results are received it shall be so noted on the 'Tracking Log' with the physician notified of the results in accordance with the 'Notification Guidelines'...." 3.1-49(f)(4)			

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R0033	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to ensure information related to the contact numbers for advocacy agencies were posted where residents could easily access for 1 of 1 main entrances to the Residential Unit of the facility. This had the potential to effect 30 of 30 residents residing on the Residential Unit. Findings include: During the environmental tour with the Administrator on 2/28/12 at 11:15	R0033	All the residents residing on the Residential unit have the potential to be affected by this alleged deficient practice. All residents residing on the unit were given a copy of the required phone numbers including the name and phone number of the Ombudsman as well as the number to call in a complaint to the Indiana State Department of Health. Current and future residents of the Residential unit have the potential to be affected by this alleged deficient practice. A copy of the required posting of phone numbers has been posted on the wall outside the Activity	03/23/2012

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	a.m., the following concerns were identified: A. The telephone number for the Ombudsman was not observed to be posted. B. The number for residents to call in a complaint to the Indiana State Department of Health was not observed to be posted. During an interview with the Administrator on 2/28/12 at 11:30 a.m., she indicated the information should have been posted on the Residential Unit. She indicated she would get the information posted as soon as possible.		room in an area readily accessible to the residents. To ensure that this alleged deficient practice does not re-occur, the posting will be audited each month by the Social Service Director and updated for any changes that may occur.The monthly audits of the required postings will be reviewed at our monthly Quality Assurance meeting X 6 months to ensure they are accurate and readily accessible to the residents residing on the Residential Unit. Executive Director, Social Service Director to monitor.	

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R0042	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to ensure information related to the most recent survey was posted where residents could easily access for 1 of 1 main entrances to the Residential Unit of the facility. This had the potential to effect 30 of 30 residents residing on the Residential Unit. Findings include: During the environmental tour with the Administrator on 2/28/12 at 11:15 a.m., the survey results from the last survey were not observed. During an interview with the Administrator on 2/28/12 at 11:30 a.m., she indicated the survey results should have been posted on the Residential Unit. She indicated she would get the information posted as soon as possible.	R0042	All residents residing on the residential Unit have the potential to be affected by this alleged deficient practice. A copy of the survey book was placed on the table in the lobby of the Residential Unit. All residents residing on the unit were infomed in writing and verbally of the location of the Survey Book. Current and future residents of the Residential Unit have the potential to be affected by this alleged deficient practice. A copy of the current survey will be in a book on the table in the lobby of the Resiential Unit. A statement informing residents and visitors of the location of the survey book will be posted on the wall outside the activity room. To ensure that this alleged deficient practice does not recur, the book will be audited weekly by Social Services to verify it is complete and readily available in the designated location. The audits will be reviewed weekly for 8 weeks and monthly X 6 months to ensure substantial compliance is achieved. The results of the audits will be reviewed at the monthly Quality Assurance Committee X 6 months.	03/23/2012

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			Executive Director/Social Service to monitor.	